**The Siren**

**BLS and Public Narcan Access:**

*One more weapon in the battle with deadly opiate abuse*

Naloxone hydrochloride (Narcan), a drug that interferes with opioid receptors and ends an opiate/opioid abuser’s “high” almost instantly, has long been available on the ALS level. It appears that it will also be available to BLS providers and, ultimately, to the trained public. Opiate and opioid abuse has reached epidemic proportions in the US, and death by overdose is growing proportionally.

This article is from the latest issue of the NYSVARA “Blanket” Newsletter:

The nasal Narcan info is from a number of sources while the Controlled Substance item is from a message from Lee Burns, Director of the Bureau of EMS to County EMS Coordinators and others.

The State Emergency Medical Advisory Committee (SEMAC) has approved a proposal to allow basic life support emergency medical services agencies and certified first responders to carry a version of the overdose reversal drug naloxone hydrochloride, marketed under the name Narcan. Intranasal Narcan is sprayed into the nostrils instead of injected into the body and reverses the respiratory depression that can result in death caused by an overdose of opioid-based drugs such as prescription painkillers and heroin. Several counties have been involved in a pilot project the past year or so and have reported very good results.

This measure, if approved by the director of the Bureau of EMS and the Commissioner of the Department of Health, will allow BLS ambulance and first responder agencies carry and administer intranasal Narcan. In addition, the current but little known “Friends and Family” intranasal Narcan program will be developed into a “Public Access Narcan” program similar to the AED and Epi Auto-injector programs.

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**An Effort to Expand Access to a Drug That Could Save Victims of Overdoses**

By JULIE TURKEWITZ
New York Times - Published: August 21, 2013

This recent NY Times article goes into detail about Narcan pilot program, public access, and pros (many) and cons (virtually none) of widening access to Narcan. This is an excerpt. Read the full article at:

http://www.nytimes.com/2013/08/22/nyregion/training-to-apply-a-drug-is-urged-in-overdose-cases.html?_r=1&

On Long Island and across New York State, drug overdoses are taking an increasing toll. The most common killers are opioids, a class of painkillers that includes prescription drugs like Vicodin, OxyContin and Percocet, as well as illegal narcotics like heroin.

In Suffolk and Nassau Counties, the two that make up Long Island, 338 people died of opioid overdoses in 2012, up from 275 in 2008, according to county records. Statewide, opioid overdoses killed 2,051 people in 2011, more than twice the number that they killed in 2004.

The spate of deaths is spurred, in part, by the easy access to prescription drugs . . .

Some public health experts and antidrug advocates, however, are offering another way to prevent overdose deaths: naloxone, an easy-to-administer, inexpensive drug that is sprayed into the nose or injected into the body. The more people who carry it, they say, the better.

A . . . statewide effort is aimed at getting naloxone into the hands of people without medical training, an effort spurred by a 2006 New York law that made it legal for community organizations and health departments to deliver naloxone training. . . . People who might seek training could include parents of addicts or a volunteer who works with substance abusers.

A list of organizations that provide naloxone training is available on the State Health Department’s Web site.
Noteworthy

We have a few new probationary members aboard with us:

Ivy Ambler - Youth Corps
Jenae McLeish - Youth Corps
Taisha Boscio
Basil Aaron
Desrene Ranglin
Marvin Torchon

Please show them support within our organization.

Willie --
Membership Committee

General
Membership Meeting,
second Thursday of each month
7:30 pm at the corps building

Officer Contact Information

<table>
<thead>
<tr>
<th>Rank</th>
<th>Name</th>
<th>Radio</th>
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<tr>
<td>Captain</td>
<td>Paul Morer</td>
<td>1</td>
<td>917-817-1867</td>
<td><a href="mailto:Paul.Morer@NyackEMS.org">Paul.Morer@NyackEMS.org</a></td>
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<tr>
<td>Lieutenant</td>
<td>Ivan Guerra</td>
<td>2</td>
<td>845 304 0246</td>
<td><a href="mailto:Ivan.Guerra@NyackEMS.org">Ivan.Guerra@NyackEMS.org</a></td>
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<td><a href="mailto:Morgan.Ambler@gmail.com">Morgan.Ambler@gmail.com</a></td>
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CONGRATS TO NEW PARAMEDICS!

Members: Morgan Ambler and Paul Morer,

Paid Staff: AJ Briones, Shannon, Steve
NCAC 2014 OFFICERS & ADMINISTRATION NOMINATIONS SLATE

The nominating committee has announced the nominations slate for 2014.

President & Safety Officer - William McDowell
Vice President - Administration - Steve Borton
Vice President - Operations (Captain) - Paul Morer
Secretary -
Board Members at Large (3) - Deirdre Denehy
Training Officer- Willie White
Lieutenants -
  1st: 
  2nd: 
  3rd: 
Legal Counsel - Duncan Lee, esq.
Medical Director - Dr. Mark Papish
Chaplain - Fr. Richard Gressle

You must have attended five meetings in the last eleven months to both vote and be nominated from the floor if your not on the presented slate. Self nominations are not permitted.

If there are vacancies after the election process, the board will appoint members to fill those vacancies.

The election will take place at the December general membership meeting (Thurs. Dec. 12, 7:30 pm).

--- Steve Borton, Nominations Committee

The Eight-Minute Response Time Standard: A Brief History

Starting now, the NCAC website home page will not only feature call stats, but also our response times expressed as an average for the previous month. The following history of EMS response time standards is excerpted from a Washington DC Fire Service research paper (pp. 34-36). See the full citation and link at the end of this article to access the entire paper via the FEMA website.

[Emergency medicine organizations and governing bodies began seeking and proposing response time standard as early as the 1970s.] The Emergency Medical Services Systems Act of 1973 (amended in 1976), directed that 95% of all requests for emergency medical service should be met within 30 minutes in rural areas, and within 10 minutes in urban areas.

The 1993 edition of the “Standards for the Accreditation of Emergency Ambulance Services,” issued by the Commission on Accreditation of Ambulance Services (CAAS), lists 55 standards for EMS systems, of which only one directly addresses system performance expectations for response time. The CAAS standard for response times (201.05) reads:

It is recommended that the local response time standards be aligned with the clinically determined optimal response time standard of eight minutes, which when calculated to the second shall not exceed eight minutes and fifty-nine seconds (0:08:59). This standard applies to systems where first responder services are also in place and should be maintained with a high degree of reliability... Response times shall be calculated by computing the difference in time from where the location of the patient, the call-back number of the calling party and probable complaint are known (if possible) until the time when an appropriate responding crew advises they have arrived at the scene.

continued on next page.
The concept of the eight-minute standard for response to critical medical calls was first broadly promulgated in the fire and EMS service by the American Heart Association (AHA), which establishes the guidelines for Advanced Cardiac Life Support (ACLS) and publishes the associated textbook. The 1987 edition of the ACLS textbook cited the late 1970s/early 1980s research of Dr. Mickey Eisenberg in King County, Washington to support the following position: “To maximize chances of survival, the delay from onset of cardiac arrest until CPR and definitive care [defibrillation/ACLS] should be kept as short as possible, ideally to 4 and 8 minutes, respectively” (p.4).

The AHA recommendations were eventually adopted by the National Fire Protection Association (NFPA) during the development of NFPA 1710: Standard for the Organization and deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments. The initial draft of NFPA 1710 (2001 edition) set a benchmark of eight minutes, 59 seconds or less for arrival of ALS resources at an emergency medical incident. The NFPA 1710 (2001 Edition) as finally adopted, now states: [Section ] 4.1.2.1.1 The fire department shall establish the following time objectives:

1) one minute (60 seconds) for turnout time...
3) four minutes (240 seconds) or less for the arrival of a unit with first responder or higher level capability at an emergency incident
4) eight minutes (480 seconds) or less for the arrival of an advanced life support unit at an emergency medical incident, where this service is provided by the fire department

4.1.2.1.2 The fire department shall establish a performance objective of not less than 90 percent for the achievement of each response time objective specified in 4.1.2.1.1. (p. 6)

NFPA Standard 1710 (2001 edition) also provides the following definition of response time as an interval distinct from call processing time and turnout time: “[Response time is] the time that begins when units are en route emergency incident and ends when units arrive at the scene” (p. 6).

The Eight-Minute ALS Response Time Standard: A Review and Discussion of Its Use as a Strategic Result Goal by the District of Columbia by Rafael Sa’adah District of Columbia Fire and Emergency Medical Services Department, September 2004.

TRAINING NOTES

From: WILLIE WHITE, NCAC TRAINING OFFICER

For those EMTs that are enrolled in our CME Program. There are some members in compliance, if you are not sure, please see me to review your file. If you are thinking about taking the EMT Class or refresher, you should take these online classes. After you have completed the on-line classes, please print your certificate and place a copy in my box. In reality, this wouldn’t hurt for the whole membership to take these classes, as it will help us in the future should we seek government grants.

From: Deschino, Frank
Subject: NYS CME Based Refresher Program requirements

Beginning 01-01-2014 you will have to show proof of completing ICS 100, 200, 700, 800 and a Haz Mat Awareness level course. All of these classes are available via FEMA’s Independent Study website. http://training.fema.gov/IS/

If have completed any of these classes in the past 10 years and have proof of successful completion you do not need to retake them. The HAZ Mat awareness course is IS 5. You can use the hours from completing these courses towards your non-core hours if you are taking them in your new re-certification cycle.

AHA ISSUES ISCHEMIC STROKE GUIDELINES

The American Heart Association/American Stroke Association has updated its comprehensive acute stroke care guidelines, which were previously updated in 2009. The guidelines followed the usual AHA/ASA classification of recommendations and levels of evidence. Updates include added emphasis on the need to transport patients to stroke centers and door to needle times for tissue plasminogen activator (TPA). For more information go to http://stroke.ahajournals.org/content/44/3/870

FREE Flu Shots for all Members

Nyack Hospital will be providing free flu shots for all members (paid, volunteer, youth corps). All that is needed is proof of membership. Please see any line officer for this if you do not have an active ID card. All are encouraged to be vaccinated.

Good Samaritan Hospital, EMS Room:

Thursday November 7th, 11AM - 1PM & 6PM - 8PM

Nyack Hospital, Pharmacy Office conference room:

Tuesday November 12th, 3 to 5PM & 9PM to 11PM
Tuesday November 19th, 8 to 10AM & 9PM to 11PM
CME and training opportunities in the area

Following are local training and CME opportunities. For more complete information, changes and additions, check the training board at the NCAC building frequently for postings of CMEs and required training for corps members.

You can also log on to www.hvremsco.org and click on CME for last minute changes and additions to area training.
Also consult www.wremsco.org/ for Westchester area CMEs, training classes and conference notices.

If you know of any training opportunities that are not listed here, or on the training board, please bring them to the attention of training officer Willie White.

NOTE: CHECK THE TRAINING BOARD AT THE BUILDING FREQUENTLY FOR NEW TRAINING CLASSES.

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revised June 2013

Log in to the **NCAC website**
and see “Member Resources”
for numerous training opportunities
throughout the year.

DID YOU KNOW?
that the HVREMSCO TRAINING PAGE
is where you can find all
upcoming EMT original and
refresher courses AND CME
classes, along with contact
information, available in the
entire Hudson Valley Region,
including Rockland County
(excludes Westchester).
Go to:
http://www.hvremsco.org

AND DID YOU KNOW?
that there are numerous
training opportunities just a
short ride away in Westchester
County, many of them at
Westchester Medical Center in
Valhalla.
Go to
http://emergencyservices.
westchestergov.com
and click on Training Classes.
Or click on
About Us/Email Sign-Up
to receive notices of all
training classes.
Any experienced EMT or medic will tell you NOT to believe your ears (dispatch info) or your eyes (the apparent problem), and that goes double for those calls that are most common in your area. In NCAC's call area we have a college, a high school and a huge shopping mall, and at those locations we have answered calls for what appears to be a panic attack -- typically a young woman under stress from a breakup, final exams, work or family problems . . . Treat it like “just a panic attack” and you (and your patient) may be in for a nasty surprise. An article in the current JEMS online (excerpted here) details such a call, and reminds us never, for one second, to take a “routine” call for granted.

Monday, October 7, 2013
Dennis Edgerly, EMT-P

Freaking Out
What seems like a panic attack could be much more serious

A 25-year-old female is obviously upset as you walk into the office suite. She's sitting in a chair, anxious and crying. Her coworkers explain she's been getting over a breakup with her long-time boyfriend, who left her about a month ago. This afternoon she became anxious, stating she couldn't breathe. Her coworkers attempted to calm her down, but called 911 after having no success.

Your assessment reveals the patient is healthy. She tells you she was sitting at her desk when she experienced a sudden onset of dyspnea. She is short of breath and her left chest hurts. Her skin is warm and dry to the touch. Her heart rate is 110, blood pressure is 112/80 and respirations are 20 with no noted accessory muscle use. Breath sounds are clear in all fields. Her capnogram reveals a normal waveform with an end tidal value of 30 mmHg and a pulse oximetry reading of 90%. Her chest discomfort is not reproducible with physical palpation, but is made worse with deep breaths.

The remainder of her physical exam is unremarkable and she denies any recent traumatic events. She denies recreational drug use but says she smokes cigarettes on occasion with a recent increase in frequency. When asked about medications, she says she takes Klonopin (clonazepam), a multivitamin, and, recently, a friend told her to try valerian root to help with the anxiety caused by her breakup.

Oxygen is administered via a non-rebreather mask that causes slight relief of the dyspnea but no notable change in pulse oximetry readings. Her respiratory rate decreased with no appreciable change in capnography.

The patient tells you she feels better and thinks she just “freaked out” and will be fine. Concerned about her chest pain and the low pulse oximetry reading, you convince the patient to go to the hospital. During transport, you continue the administration of oxygen with no change in pulse oximetry and establish vascular access. Her vital signs don't change. Follow-up with the ED revealed the patient had a pulmonary embolism (PE).

Subtle Killers

It can be easy to attribute the signs and symptoms caused by a PE to other factors. In the case of the patient described here, the EMS providers could have accepted the patient's evaluation of just “freaking out” and allowed her to remain on scene. In one study of patients who died from pulmonary embolisms, it was determined 40% had recently seen a physician for treatment of symptoms attributable to PE.

Pulmonary embolisms are commonly missed by healthcare providers at all levels due to their sometimes subtle presentation. Another study identifies PE as the most-commonly missed or delayed diagnosis. A set of criteria known as the Wells Scoring System is sometimes used by emergency physicians to help identify the probability of PE. EMS can use components of the Wells Scoring System to help identify patients who are likely to have a PE.

In order of significance, providers should consider PE if:

- There is no other obvious cause of shortness of breath;
- Clinical signs of DVT (e.g., a swollen leg) are presented;
- There is a history of PE or DVT;
- Heart rate is greater than 100 bpm;
- The patient recently had surgery or long-term immobilization;
- Hemoptysis (coughing blood) is presented; or
- The patient was treated for cancer within the past six months.

Read the entire article at:
http://m.jems.com/article/patient-care/common-panic-attack-symptoms-could-be-so-o
Members Discounts!

We are compiling a list of local merchants who offer discounts to NCAC members. Merchants currently offering discounts are listed here, and on our website in the “Members” area.

Please ask the local merchants whom you patronize if they would be willing to offer a discount to their local EMS volunteers. We will list them in our newsletters, on our website, and encourage our members to do business with them.

Supporting our local merchants will also help keep Nyack (and the other river villages) from turning into chain store wastelands.

Charlie’s Cleaners,
10% off dry cleaning
2 S. Highland Ave (9W)
Nyack, NY
Account Name: Nyack Community Ambulance Corps
Contact phone: 358 4824
Members be sure to put your own name on store receipt to avoid pickup mixups.

Nyack Barber Shop
69 Main Street
Nyack, NY
$2 off haircut

Johnny Cakes
84 Main Street
Nyack, NY
10% off eat-in or carry-out orders

Pet Nutrition Center
115 Route 59
Nanuet, NY
5% off pet food and supplies

Dapper Dog
37 Route 59
Nyack, NY
5% off pet food and supplies

Temptations,
80 1/2 Main Street
Nyack, NY
15% off all purchases

Turiello’s,
76 Main Street,
Nyack, NY
10% off eat-in or carry-out orders

Tarantella’s
128 Main Street
Nyack, NY
10% off eat-in or carry-out orders

REMINDER: smoking is banned on NCAC corps property.
If you must smoke while on duty, you are limited to your car. Make sure all debris associated with your smoking leaves the property with you.
EMT-Basic - CME Recertification Program Checklist

- 24 hours of Refresher Training (review of core content)
  - Preparatory (1)
  - Airway (2)
  - Patient Assessment (3)
  - Medical/Behavioral (8)
    - General Pharmacology/Respiratory/Cardiac (4)
    - Diabetes/Altered Mental Status/Allergies (2)
    - Poisoning/Environmental/Behavioral (2)
  - Trauma (4)
  - Obstetrics/Gynecology (2)
  - Infants and Children (2)
  - Elective (2)

- 48 hours of additional continuing education requirements, which must include:
  - Geriatrics (minimum of 3 hours)
  - WMD/Terrorism (minimum of 3 hours)

A maximum of 12 hours for "core content" and 24 hours for additional CME hours may be credited for self-study activities through documented continuing education via publications, video and/or Internet training.

A maximum of 6 hours may be credited for teaching CPR courses and this can only be used once for each recertification period.

A CIC who teaches an original or recertification course can claim the maximum hours for the "core content" area only.

National continuing education programs like PHTLS, BTLS, PALS, ACLS, AMLS, SCOPE, PEPP, GEMS, etc. may be used towards "core content" areas or for additional CME areas. Please contact our office for guidance.

A maximum of 12 hours may be credited for any one specific topic.

See the program guidelines at the DOH website for the latest information.
Supplemental 13 hours - NEW! - for CME recertification

The following required hours must contain the new educational components from the NYS Educational Standards. These CME hours are above and beyond CME hours under the previous NYS curriculum and have been documented on the old CME renewal forms. All certified providers must complete these transition CME hours for certification renewals starting on December 20, 2012 unless they are submitting the new CME forms for the new Standards. All providers must complete their renewal process, including these transition CME hours, by their next renewal date or June 30, 2014, whichever comes first. Please check our web site for additional information pertaining to the transition to the National Educational Standards.

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**TOTALS** 13.0
NAEMT ANNOUNCES EMS FITNESS GUIDELINES

Lack of physical fitness within EMS agencies contributes to injuries and an increase in chronic diseases. EMS practitioners are seven times more likely than the average worker to miss work as a result of injury, and one in four EMS practitioners will suffer a career-ending injury within the first four years of service. Back injury alone is the primary reason practitioners leave EMS.

In an effort to reduce injuries from patient movement, improve practitioner health and create a safer EMS work environment, NAEMT established a formal relationship with the American Council on Exercise (ACE) to create the Task Performance and Health Improvement Recommendations for Emergency Medical Service Providers.

ACE exercise physiologists observed EMS practitioners bending, twisting, reaching, pushing, pulling and maneuvering while providing patient care. These repetitive motions were often done in tight spaces. ACE personnel also observed the external loads imposed by carrying or moving patients and equipment. The team used the site visits, ride-along encounters and staff interviews to generate initial observations and a practitioner task analysis. The results of the efforts were found to be consistent from site to site.

The recommendations are designed to achieve the following primary outcomes:
- improve job-related physical capacity,
- improve overall wellness;
- and create self-reliance.

Chemical suicide, also known as detergent suicide, is an increasingly common method of committing suicide. It is often communicated as an easy, quick and painless way to end one’s life. The technique originated in Japan but has been spreading across the United States via instructions posted on the Internet. Chemical suicide involves mixing two or more inexpensive, common household chemicals in an enclosed space. The chemical mixtures produce a heat-releasing — or exothermic — reaction and create toxic gases that quickly fill an enclosed area.

Chemical suicides typically occur in personal vehicles, closets, bathrooms and other small, confined spaces where the concentration of gas can quickly accumulate to levels that are lethal not only to suicide victims but also to emergency responders. To prevent injury or death to emergency responders reporting to chemical suicides, it is essential to conduct a careful and detailed scene assessment and patient size-up in any situation involving an unresponsive person in an enclosed space.

Below are key indicators of potential chemical or detergent suicide scenes:

— Unresponsive subject inside the vehicle. Subject committing suicide with the proper chemical mixtures will be dead instantly. Subject may have a seatbelt fastened to prevent his or her body from falling onto the horn and alerting others.
— Subject wearing goggles or gloves to prevent chemical burns before his or her death.
— Warning signs (such as HAZMAT or SUICIDE) taped to the window or door of a vehicle or room.
— Yellow/Green or white residue on a vehicle’s seats or dashboard. This residue has been found in almost all chemical suicide cases.
— Windows fogged or tinted with yellow/green residue.
— Pennies in the vehicle or vehicle console area will be tarnished with residue.
— Smell of rotten eggs or sulfur, indicating the presence of hydrogen sulfide.
— Smell of bitter or burnt almonds, indicating the presence of hydrogen cyanide.
— Empty household cleaning containers on the floorboard or seat of a vehicle.
— One or more large buckets visible.
— Vehicle’s inside door handles removed, which prevents a subject who has changed his or her mind from stopping the suicide process.
— Duct tape, plastic or towels to cover air vents, windows and doors. This prevents the deadly chemical mixture from seeping out.